HIV/AIDS Monitoring Report

Department of Health and Human Services

Data through December 31, 2002

The mission of the City of Long Beach Department of Health and Human Services is to improve the quality of life of the residents of Long Beach by addressing the public health and human service needs ensuring that the conditions affecting the public's health afford a healthy environment in which to live, work and play.

The SHAS Project: A Population-Based Study of Persons with AIDS

Since 1990, the Supplement to HIV/AIDS Surveillance (SHAS) Project has collected descriptive and risk behavior information on persons diagnosed with AIDS in Los Angeles County. The SHAS Project is a U.S. Centers for Disease Control and Prevention (CDC)-sponsored study that is conducted in 19 U.S. sites. Locally, SHAS is implemented by the Los Angeles County Department of Health Services HIV Epidemiology Program.

SHAS is an important project because it is the only population-based study designed to represent all persons diagnosed with AIDS in Los Angeles County. Persons with AIDS who are at least 18 years of age and reported to the Los Angeles AIDS Case Registry are eligible to participate. HIV-infected women treated at one large public HIV clinic are also included. With HIV reporting currently underway in California, HIV-positive non-AIDS patients reported in Los Angeles County will be interviewed for SHAS beginning in July 2003.

Participation in SHAS is voluntary. Patients are contacted through their providers at public and private sites that diagnose and report persons with AIDS. Participating SHAS health care providers include LAC+USC, Harbor/UCLA, Kaiser Permanente, and AIDS Healthcare Foundation. Trained SHAS interviewers administer a standardized questionnaire to participants within two years of their AIDS diagnosis, either as part of a routine visit to their medical facility or at another mutually agreed upon location. The SHAS questionnaire, developed in consultation with the state/local SHAS project officers, CDC epidemiologists, and subject area consultants, includes information on demographic characteristics; sexual behaviors and STD history; drug and alcohol use; reproductive/gynecological history; HIV testing and medical therapy; and health and social services. SHAS is useful for identifying groups in need of prevention services and can be used to characterize barriers that prevent persons from accessing services. SHAS participants receive $20.00 for their time and all information obtained is completely confidential.

SHAS data are used at the state and local levels to inform policy makers

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and others involved in HIV prevention and care. At the national level, these data are used to enhance HIV/AIDS surveillance information used for planning and allocation of resources. The SHAS Project Los Angeles staff includes the Principal Investigator, Amy R. Wohl, Ph.D., Project Coordinator Denise Fearman Johnson, M.P.H., and the SHAS Interviewers Alexander Carruth and Efrain Reyes. For more information on the SHAS Project, please contact Denise Fearman Johnson at (213) 351-8545.

HIV EPIDEMIOLOGY PROGRAM

Introduction

Comprising nearly 50 square miles at the southernmost end of Los Angeles County, Long Beach has approximately a half-million residents, making it the fifth largest city in California and the 32nd largest in the United States (based on U.S. Census 2000). One of 61 health jurisdictions in California, the City of Long Beach has maintained the Health Department for more than 90 years.

Its size, diversity and geographic location in a major population center have made Long Beach particularly vulnerable to HIV and AIDS. With a cumulative incidence rate of 940.58 AIDS cases per 100,000 residents (1981 through December 31, 2002), Long Beach's AIDS incidence rate per capita is almost 100 percent higher than the incidence rate for all of Los Angeles County (474.39 cases per 100,000) and more than double the rate for the State of California overall (378.48 cases per 100,000), indicating that AIDS continues to be a significant public health issue in the City of Long Beach (Table 1).

Table 1
Comparison of City of Long Beach, Los Angeles County and California Cumulative AIDS Incidence Rate per 100,000 Population, 1981 through December 31, 2002.

	2000 Population	Number of AIDS Cases	Cumulative AIDS Incidence Rate
City of Long Beach	461,522	4,341	940.58
Los Angeles County	9,519,338	45,159	474.39
California	33,871,648	128,196	378.48

Sources: California HIV/AIDS Reporting System, December 31, 2002
Long Beach HIV/AIDS Reporting System, December 31, 2002

The California Code of Regulations, Title 17, Section 2500, requires that all diagnosed or suspected cases of AIDS as defined by the Centers for Disease Control and Prevention (CDC) be reported within seven days to the local Health Officer. To facilitate reporting, the City of Long Beach Department of Health and Human Services maintains an HIV Epidemiology Program (funded by the State of California Department of Health Services Office of AIDS) which is responsible for collecting, analyzing and disseminating AIDS data.

Cumulative Cases

Since its first AIDS case report in February 1983, a cumulative total of 4,341 AIDS cases has been reported in Long Beach through December 31, 2002. The cumulative case fatality rate of 56% percent is lower than California (60%) and Los Angeles County (62%). Of the 4,341 reported AIDS cases, 1,895 people are currently living.

Race/Ethnicity

Of the 4,341 cumulative AIDS cases, approximately two-thirds (62.0%) are White (Table 2). While Whites still comprise the majority of the reported cases, the number of HIV infections may be decreasing in this group. From January 2002 through December 2002, the percentage of AIDS cases reported in Whites was 53.0 percent. AIDS cases in Blacks, while contributing 17.4 percent to the cumulative cases, comprised 19.1 percent of the cases reported in the past year. Hispanic AIDS cases comprised more than one-quarter (26.3%) of the cases reported in the last year, yet they make up 18.7 percent of the cumulative cases. The percentage of cases among Asian/Pacific Islanders during the past year (1.6%) is less than the 1.8 percent reported cumulatively (Table 2).

Table 2
Cumulative AIDS Cases by Race/Ethnicity and Percent of Population Reported 1981 through December 31, 2002, City of Long Beach

	2000 Population	Percent of Population	Number of AIDS Cases	Percent of AIDS Cases
White, Not Hispanic	152,899	33.1%	2,682	62.0%
Black, No Hispanic	66,836	14.5%	755	17.4%
Hispanic	165,092	35.8%	812	18.7%
Asian/PI	60,329	13.1%	79	1.8%
Amer.Ind./Alaska Nat.	2,785	1.0%	11	0.3%
2 or More Races	13,581	2.9%	N/A*	N/A*
Not Specified			2**	<0.1%
TOTAL	461,522	100%	4,341	100%

* Not collected for report period
** These cases are pending investigation. Upon identification of race/ethnicity,

Gender

The vast majority of AIDS cases in Long Beach are male (93.8 percent). However, the increasing percentage of female AIDS cases being reported each year suggests that more women may be becoming infected. During January 1, 2002 - December 31, 2002, 7.6 percent of the cases reported were in females, compared with a cumulative percentage of 6.2 for cases reported as of December 31, 2002 (Table 3).

Table 3
AIDS Cases by Report Date and Gender, Reported January 1, 2002 through December 31, 2002, and Cumulative Totals through December 31, 2002, City of Long Beach.

	January 2002 – December 2002	1981 – December 2002
Male	281 (92.4%)	4,072 (93.8%)
Female	23 (7.6%)	269 (6.2%)
TOTAL	304 (100%)	4,341 (100%)

Age

Through December 31, 2002, almost half (48.0%) of the cumulative AIDS cases in Long Beach were diagnosed among people between the ages of 30 and 39. More than one-quarter of all cases were diagnosed among people between the ages of 40 and 49. This indicates that the majority of people with AIDS in Long Beach were infected in young adulthood. Fifteen percent of AIDS cases were diagnosed in people in their twenties, suggesting that a significant number of people with AIDS became infected during adolescence (Table 4).

Table 4
Cumulative AIDS Cases by Age Group and Gender, Reported 1981 through December 31, 2002, City of Long Beach.

	No. of Male Cases	No. of Female Cases	TOTAL
Under 13	5 (0.1%)	4 (1.5%)	9 (0.2%)
13-19	11 (0.3%)	6 (2.2%)	17 (0.4%)
20-29	596 (15.0%)	64 (23.4%)	660 (15.2%)
30-39	1,979 (48.6%)	106 (39.0%)	2,085 (48.0%)
40-49	1,071 (26.3%)	60 (22.3%)	1,131 (26.0%)
Over 49	410 (10.0%)	29 (11.0%)	439 (10.0%)
TOTAL	4,072 (100%)	269 (100%)	4,341 (100%)

Exposure Category

Almost eighty-one percent of all adult male AIDS cases reported through December 31, 2002 in Long Beach reported male-to-male sexual contact (MSM) as a mode of transmission. An additional 9.1 percent reported both male-to-male sexual contact and injection drug use (IDU). Nearly seven percent of male AIDS cases reported injection drug use as the sole risk behavior. Over one percent of male cases report being infected through heterosexual contact (Table 5).

Among women in Long Beach, however, heterosexual contact and injection drug use are the prevalent modes of HIV transmission. Of all adult female AIDS cases reported in Long Beach, 54.0 percent were infected through heterosexual contact. Thirty-seven percent were infected through injection drug use. About four percent were infected through the receipt of blood transfusions or blood components, while the remaining cases (5.3%) have reported no risk or are currently under investigation (Table 6).
The predominant mode of HIV exposure in children is perinatal transmission (88.9%) (Table 7).

Table 5
Cumulative Adult Male AIDS Cases by Exposure Category and Race/Ethnicity, Reported 1981 through December 31, 2002, City of Long Beach.

	White	Black	Hispanic	Asian/PI	Am. Ind./Alaka Nat.	Unknown	TOTAL (Row%)
Sex between men	2,209	414	580	64	7	2	3,276 (80.6%)
Sex between men/IDU	239	70	56	1	3	0	369 (9.1%)
Injection Drug Use	113	110	53	0	0	0	276 (6.8%)
Heterosexual Contact	18	23	24	2	0	0	67 (1.6%)
With IDU	*4*	*6*	*1*	*0*	*0*	*0*	*11*
With Transfusion Recipient	*1*	*0*	*1*	*0*	*0*	*0*	*2*
With Person with HIV/AIDS	*13*	*17*	*22*	*2*	*0*	*0*	*54*
Transfusion	6	2	5	1	0	0	14 (0.3%)
Adult Hemophilia	9	1	0	1	0	0	11 (0.3%)
Pediatric Hemophilia	1	0	1	0	0	0	2 (<0.1%)
Risk Not Reported	17	14	18	3	0	0	52 (1.1%)
TOTAL (Column %)	2,612 (64.2%)	634 (15.6%)	737 (18.1%)	72 (1.8%)	10 (0.2%)	2 (<0.1%)	4,067 (100%)

Table 6
Cumulative Adult Female AIDS Cases by Exposure Category and Race/Ethnicity, Reported 1981 through December 31, 2002, City of Long

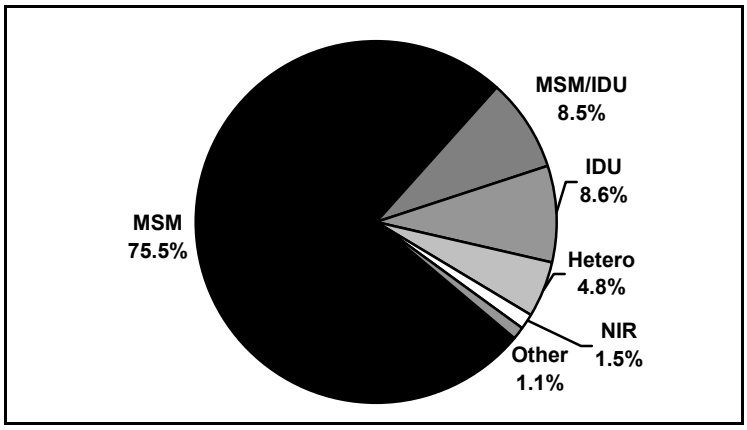
	White	Black	Hispanic	Asian/PI	Other/Unknown	TOTAL (Row %)
Injection Drug Use	27	53	16	0	1	97 (37.0%)
Heterosexual Contact	34	52	51	6	0	143 (54.0%)
With Bisexual Male	*7*	*1*	*2*	*0*	*0*	*10*
With IDU	*7*	*15*	*9*	*0*	*0*	*31*
With Transfusion Recipient	*0*	*0*	*0*	*2*	*0*	*2*
With Hemophiliac	*0*	*1*	*1*	*0*	*0*	*2*
With Person with HIV/AIDS	*20*	*35*	*39*	*4*	*0*	*98*
Transfusion	5	3	1	1	0	10 (3.8%)
Pediatric Hemophilia	0	1	0	0	0	1 (0.4%)
Risk Not Reported	2	9	3	0	0	14 (5.3%)
TOTAL (Column %)	68 (25.7%)	118 (44.5%)	71 (26.8%)	7 (2.6%)	1 (0.4%)	265 (100%)

Table 7
Cumulative Pediatric AIDS Cases by Exposure Category and Race/Ethnicity, Reported 1981 through December 31, 2002, City of Long Beach.

	White	Black	Hispanic	TOTAL (Row %)
Mother with Risk	1	3	4	8 (88.9%)
Transfusion	1	0	0	1 (11.1%)
TOTAL (Column %)	2 (22.2%)	3 (33.3%)	4 (44.4%)	9 (100%)

Combined, over three-quarters (75.5%) of Long Beach AIDS cases report sex between men as a risk factor. Almost nine percent report intravenous drug use. Another eight percent report both sex between men and injection drug use. Almost five percent of Long Beach cases report heterosexual contact as the sole risk. Slightly more than one percent of AIDS cases in Long Beach are the result of a blood/blood product transfusion or pediatric transmission. The remaining cases did not report a risk or are currently under investigation to elucidate possible modes of transmission further (Figure 1).

FIGURE 1
CUMULATIVE AIDS CASES BY EXPOSURE CATEGORY, REPORTED 1981 THROUGH DECEMBER 31, 2002, CITY OF LONG BEACH.



Total Cases = 4,341
Other = Transfusion or transplant recipient, hemophilia, and pediatric cases.

AIDS Defining Conditions

The AIDS surveillance system represents cases that have met the AIDS case surveillance reporting criteria established by the CDC. In 1993, the AIDS surveillance case definition was expanded to include a laboratory measure of severe immunosuppression (CD4+ T-lymphocyte counts of less than 200 cells/µl or a percent of total lymphocytes less than 14), pulmonary tuberculosis, invasive cervical carcinoma, and recurrent bacterial pneumonia. Prior to 1993, the surveillance definition included only opportunistic illnesses.

Mortality Rates

Table 8 presents the annual and cumulative fatality rates of AIDS cases reported in Long Beach by the year of diagnosis. The presented rates are comparable to those of Los Angeles County, California, and the United States.

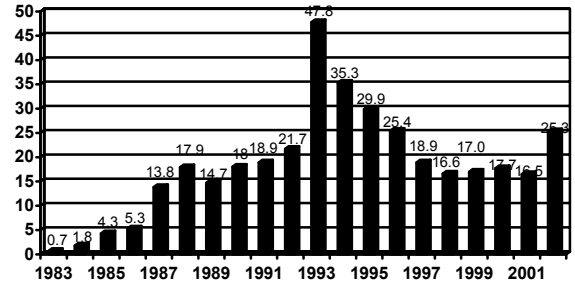
TABLE 8
AIDS CASE MORTALITY BY YEAR OF DIAGNOSIS, REPORTED 1981 THROUGH DECEMBER 31, 2002, CITY OF LONG BEACH.

Year	Diagnosed Cases	Deaths	Fatality Rate for Cases Diagnosed in Year	Cumulative Fatality Rate
Before 1988	413	406	—	98%
1988	220	217	99%	98%
1989	228	200	88%	96%
1990	295	262	89%	94%
1991	372	318	85%	92%
1992	414	329	79%	89%
1993	361	230	64%	85%
1994	309	155	50%	81%
1995	327	111	34%	76%
1996	284	63	22%	71%
1997	226	43	19%	68%
1998	184	33	18%	65%
1999	207	25	12%	62%
2000	196	30	15%	60%
2001	178	14	8%	58%
2002	127	10	8%	56%
TOTAL	4,341	2,446	—	56%

Impact of Changes in the AIDS Case Definition

The surveillance definition of AIDS was modified in 1985, 1987 and 1993 to reflect increased knowledge of the manifestations of HIV disease. These expanded definitions present challenges in analyzing case trends. For example, expanding the surveillance case definition in 1993 to include HIV-infected individuals with CD4+ T-lymphocyte counts below 200 cells/µl resulted in a number of new cases being reported as well as with the implementation of HIV Reporting in July of 2002 (Figure 2).

FIGURE 2
AVERAGE REPORTED AIDS CASES PER MONTH, REPORTED 1981 THROUGH DECEMBER 31, 2002, CITY OF LONG BEACH.



Survival Status

By analyzing the data presented in Table 9 and comparing relative proportions of the living and the deceased, changes in the local epidemiology of advanced HIV disease may be detected as living cases are representative of more recent infections. For instance, a higher number of Blacks (20.5%) and Hispanics (25.0%) are currently living with AIDS than are deceased (15.0% and 14.1%, respectively). This demonstrates a shift toward increasing HIV infections in minorities. Similar changes are seen in the gender, age, and exposure categories.

TABLE 9
AIDS CASES BY SURVIVAL STATUS AND DEMOGRAPHICS, REPORTED 1981 THROUGH DECEMBER 31, 2002, CITY OF LONG BEACH.

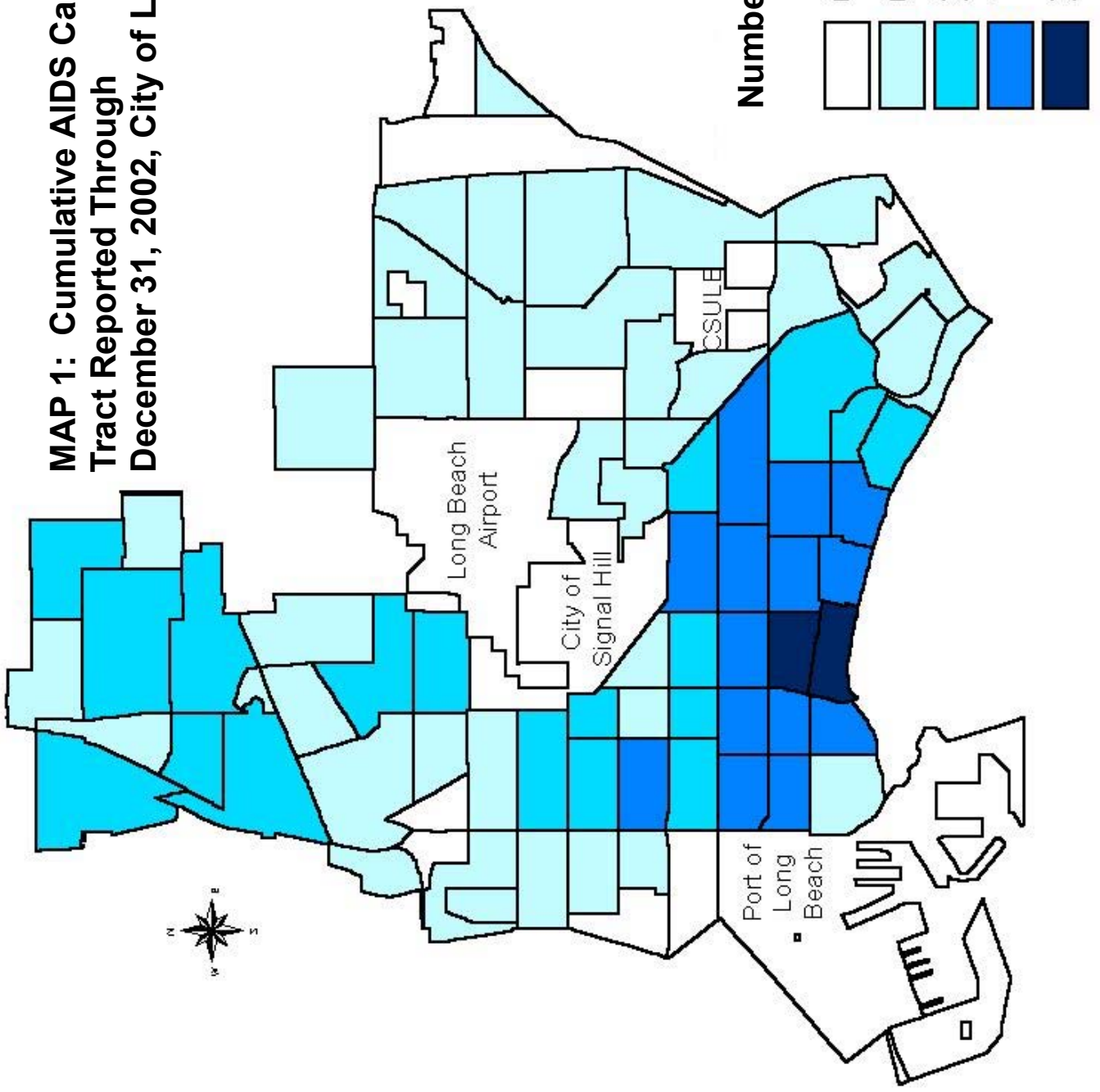
Case Profile	Living	Deceased
Gender		
Male	1,728 (91.5%)	2,339 (95.9%)
Female	161 (8.5%)	107 (4.4%)
Race/Ethnicity		
White, Not Hispanic	987 (52.2%)	1,691 (69.1%)
Black, Not Hispanic	388 (20.5%)	367 (15.0%)
Hispanic	466 (25.0%)	344 (14.1%)
Asian/PI	41 (2.2%)	38 (1.6%)
Am. Ind./Alaska Nat.	7 (0.4%)	4 (0.2%)
Unknown	0 (0.0%)	2 (<0.1%)
Age		
Age <13	3 (0.2%)	6 (0.2%)
13-19	10 (0.5%)	7 (0.3%)
20-29	294 (15.6%)	365 (15.0%)
30-39	930 (49.2%)	1,153 (47.2%)
40-49	502 (26.6%)	626 (26.0%)
50+	150 (8.0%)	289 (11.8%)
Exposure Category		
Sex between men	1,376 (72.8%)	1,898 (78.0%)
Sex between men/IDU	164 (9.0%)	203 (8.3%)
Injection Drug Use	175 (9.3%)	198 (8.1%)
Heterosexual Contact	136 (7.2%)	72 (2.9%)
Hemophilia	6 (0.3%)	8 (0.3%)
Transfusion	6 (0.3%)	19 (0.8%)
Perinatal Transmission	3 (0.2%)	5 (0.2%)
NIR	23 (1.2%)	43 (1.7%)
TOTAL	**1,889 (100%)**	**2,446 (100%)**

Geographic Information System

Geographic Information System (GIS) is a computer-based mapping technology, which combines geographical data and events such as a population, disease cases, vital statistics, socioeconomic indicators, and many other data sources to generate maps for spatial analysis. The Health Department uses GIS to monitor the health status of the community by assessing epidemiological data. This analysis determines which diseases and conditions account for the greatest morbidity and mortality in the City which allows for more localized efforts in health promotion and disease prevention efforts.

AIDS surveillance data is used to map cases by geographic location such as zip codes and census tracts in Long Beach. Geographic analysis of data allows for the provision of HIV/AIDS screening and prevention services to be targeted to individuals that are at a greater risk for infection. Mapping AIDS cases in the City may allow for a greater level of targeted outreach in the areas with a higher number of cases. Map 1 demonstrates the cumulative number of reported AIDS cases at time of diagnosis among City residents from 1981 through December 31, 2002 by census tract. This map does not take into the account the migration of individuals with AIDS moving in and out of Long Beach.

MAP 1: Cumulative AIDS Cases By Census Tract Reported Through December 31, 2002, City of Long Beach



Source: City of Long Beach Department of Health and Human Services, HIV Epidemiology Program.

HIV ANTIBODY TESTING PROGRAM

The Health Department provides both anonymous and confidential HIV antibody testing to the public. HIV antibody testing also occurs through other venues in the City of Long Beach, including private physicians, hospitals and clinics. These data reflect City-administered testing programs only.

The City has maintained data on both anonymous and confidential HIV antibody testing since the programs began. In January 1990, the California Department of Health Services, Office of AIDS implemented the HIV Test Reporting System, a computer program that collects demographics on clients and their test results to generate reports valid to local testing sites and to improve data reporting to the Office of AIDS.

"Data represents each client visit and services provided. The basic tabulated information is this client visit/service unit. A client may have made more than one HIV-related visit; each visit may be reported separately. A client may have received more than one service from different funding sources on the same visit — each reported separately. It is important to keep in mind that these data represent counseling and testing services through these programs and should NOT be interpreted as representing persons or the population of [Long Beach] in general. Recipients of these services are a highly self-selected group."

California HIV Testing and Counseling Monthly Report, 2/90

Anonymous Testing

The Alternative Test Site (ATS) program was developed for individuals wanting to know their HIV antibody status anonymously. The HIV antibody test administered in an ATS setting addressed the concern that individuals at risk for HIV infection might donate blood to determine their antibody status if blood banks were the only source of free and easily accessible testing. ATS began here in Long Beach in June 1985 and two testing sites currently exist (Table 12 and 13).

TABLE 12
ANONYMOUS HIV ANTIBODY TESTS BY RACE/ETHNICITY AND AGE GROUP, APRIL 1988 THROUGH DECENBER 31, 2002, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Race/Ethnicity				
White	48,206	56.6%	1,669	3.5%
Black	11,877	13.9%	388	3.3%
Hispanic	18,434	21.6%	629	3.4%
Asian/PI	4,586	5.4%	77	1.7%
Am. Ind./Alaska Nat.	553	0.6%	33	6.0%
Other/Unknown	1,538	1.8%	37	2.4%
Age Group				
12-19	5,325	6.3%	37	0.7%
20-29	35,080	41.2%	1,032	2.9%
30-39	26,646	31.3%	1,158	4.3%
40-49	11,787	13.8%	443	3.8%
50-59	4,220	5.0%	123	2.9%
60+	2,086	2.4%	36	1.7%
Unknown	50	0.1%	4	8.0%
TOTAL	**85,194**	**100.0%**	**2,833**	**3.3%**

* Prior to April 1988, no testing data were collected by race/ethnicity or age group.

TABLE 13
ANONYMOUS HIV ANTIBODY TESTS BY GENDER AND EXPOSURE CATEGORY, JUNE 1985 THROUGH DECEMBER 31, 2002, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Gender				
Male	69,563	67.6%	5,045	7.3%
Female	33,295	32.4%	193	0.6%
Other/Unknown	55	0.1%	0	0.0%
Exposure Category				
MSM	29,555	28.7%	3,946	13.4%
Bisexual	7,413	7.2%	590	8.0%
IDU	3,635	3.5%	94	2.6%
MSM/IDU	871	0.8%	146	16.8%
Hemophiliac	26	0.1%	4	15.4%
Transfusion Recipient	1,418	1.4%	19	1.3%
Heterosexual	28,747	27.9%	146	0.5%
High Risk Sex Partner	17,297	16.8%	173	1.0%
Occupational	756	0.7%	2	0.3%
No Risk Stated	10,995	10.7%	64	0.6%
Unknown	2,200	2.1%	54	2.5%
TOTAL	**102,913**	**100.0%**	**5,238**	**5.1%**

Confidential Testing

Confidential testing (CTS) began in 1988; this report reflects data gathered beginning January 1989. These data include individuals tested confidentially for HIV antibody status at the Health Department or through special outreach testing efforts. The confidential testing report includes data collected from tests performed at Health Department clinics.

TABLE 14
CONFIDENTIAL HIV ANTIBODY TESTS BY DEMOGRAPHICS, JANUARY 1989 THROUGH DECEMBER 31, 2002, CITY OF LONG BEACH.

	# of Tests	% of Total	# of Pos.	% Pos.
Gender				
Male	26,408	59.5%	466	1.8%
Female	17,904	40.3%	93	0.5%
Other/Unknown	97	0.2%	3	3.1%
Race/Ethnicity				
White	13,173	29.7%	177	1.3%
Black	14,502	32.7%	230	1.6%
Hispanic	12,286	27.7%	128	1.0%
Asian/PI	3,066	6.9%	14	0.5%
Am. Ind./Alaska Nat.	349	0.8%	4	1.1%
Other/Unknown	1,033	2.3%	9	0.9%
Age Group				
Under 12	18	<0.1%	0	0.0%
12-19	6,049	13.6%	11	0.2%
20-29	18,135	40.8%	188	1.0%
30-39	11,093	25.0%	231	2.1%
40-49	6,196	14.0%	96	1.5%
50-59	2,141	4.8%	24	1.1%
60+	699	1.6%	11	1.6%
Unknown	78	0.2%	1	1.3%
Exposure Category				
MSM	1,889	4.3%	163	8.6%
Bisexual	1,402	3.2%	85	6.1%
IDU	2,925	6.6%	60	2.1%
MSM/IDU	328	0.7%	49	14.9%
Hemophiliac	1	<0.1%	0	0.0%
Transfusion Recipient	246	0.6%	3	1.2%
Heterosexual	18,691	42.1%	71	0.4%
High Risk Sex Prtnr	9,907	22.3%	92	0.9%
Occupational	216	0.5%	0	0.0%
No Risk Stated	6,994	15.7%	32	0.5%
Unknown	1,810	4.1%	7	0.4%
TOTAL	**44,409**	**100.0%**	**562**	**1.3%**

TECHNICAL NOTES

These data reflect statistical monitoring activities aimed at identifying the entire range of HIV infection in Long Beach.

Data presented in this report are provisional due to reporting delays.

Surveillance and Reporting of AIDS[1]

The AIDS Classification System represents cases that have met the AIDS case surveillance reporting criteria established by the Federal Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Services. In September 1992, the CDC proposed the inclusion of three conditions: pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer, and HIV-infected adolescents and adults who have CD4+ T-lymphocyte counts less than 200 cells/µL or a CD4+ percentage of less than 14, in addition to the clinical conditions listed in the 1987 surveillance case definition. This revised classification was implemented in January 1993. Persons who meet the criteria for more than one definition category are classified hierarchically in the following order: pre-1987, 1987, and 1993. Persons in the 1993 definition category only meet the 1993 definition.

Caution should be used when interpreting monthly statistics, because they can vary month to month due to a variety of factors. Therefore, looking at the long-term trends for a complete analysis of the AIDS data is necessary. Similar caution should be used in the interpretation of small numbers cases, as analyses based on small numbers are more likely to yield incorrect conclusions due to random or systematic error.

Age group tabulations are based on the person's age at diagnosis of AIDS: adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Men who have sex with men (MSM) cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).

Heterosexual contact cases include persons who report either specific heterosexual contact with a person with (or at increased risk for) HIV infection (e.g., injecting drug use).

Undetermined cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of transmission categories. These cases include: persons whose exposures are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Race/Ethnicity[2] is classified by the individual reporting the AIDS case. Usually, race/ethnicity is self reported by the patient upon enrollment with the health care provider. The definitions below represent those classifications as effectively as possible.

White, Not Hispanic: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

Black, Not Hispanic: A person having origins in any of the black racial groups of Africa.

Hispanic: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

Asian/Pacific Islander: A person having origins in any of the original people of the Far East, South East Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.

American Indian/Alaska Native: A person having origins in any of the original peoples of North American, and who maintains cultural identification through tribal affiliation or community recognition.

Not Specified: Race/ethnicity was not identified and/or reported at the time of diagnosis and report. These cases are currently under investigation. Upon identification of race/ethnicity, cases will be reclassified into the appropriate category.

Incidence rate[3] is defined as the number of new cases of a specified disease diagnosed or reported during a defined period of time, divided by the number of persons in a state population in which the cases occurred. This is usually expressed as cases per 1,000 or 100,000 per annum. This rate may be expressed as age– or gender-specific or as specific for any other population characteristic or subdivision.

Prevalence rate[3] is defined as the total number of persons sick or portraying a certain condition in a stated population at a particular time, or during a stated period of time, regardless of when that illness or condition began, divided by the population at risk of having the disease or condition at the point in time or midway through the period in which they occurred.

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[1] Definitions used here were taken mostly from the CDC HIV/AIDS Surveillance Report, Technical Notes section.

[2] Federal Register. August 28, 1995. Volume 60, Number 166. Notices, pp. 44692-44693.

[3] Control of Communicable Diseases Manual. Abram S. Benenson, Editor. Sixteenth Edition, 1995.

HIV/AIDS RESOURCES

National Hotlines

AIDS Clinical Trials Information Services	800-TRIALS-A
CDC Hearing Impaired AIDS Hotline (TTY)	800-243-7889
CDC Labor Responds to AIDS Resource Service	800-458-5231
CDC National HIV/AIDS Hotline	800-342-AIDS
CDC Spanish HIV/AIDS Hotline	800-344-7432
CDC National Prevention Information Network	800-458-5231
CDC National STD Hotline	800-227-8922
AIDS Statistical Information Line (Recorded Information)	888-232-3299
Fax Information Service Line	888-232-3299
General Info. (including info on HIV/ AIDS) (Recorded Information)	888-232-3299
HIV/AIDS Treatment Information Service	800-HIV-0440
Project Inform (HIV Treatment Hotline)	800-822-7422
National Pediatric HIV Resource Center	800-362-0071

State AIDS Hotlines

California (Southern) (English)	800-922-AIDS
California (Southern) (Spanish)	800-400-SIDA
California (Southern) (TTY/TDD)	800-553-AIDS
California (Northern) (Spanish and English)	800-367-AIDS
California (Northern) (Tagalog)	800-345-AIDS
California (Northern) (TDD)	888-225-AIDS

NOTICE TO HEALTH CARE PROVIDERS AND OTHERS RESPONSIBLE FOR DISEASE REPORTING

California Code of Regulations, Title 17, Section 2500 requires that all diagnosed or suspected cases of AIDS as defined by CDC must be reported within seven (7) days to the Health Officer. To obtain information on the CDC AIDS case definition, to obtain case report forms or to report a case, contact:

City of Long Beach
Department of Health and Human Services
HIV Epidemiology Program
2525 Grand Avenue
Long Beach, CA 90815
Phone (562) 570-4311
www.ci.long-beach.ca.us/health

Ronald R. Arias, M.P.A.
Director
Department of Health and Human Services

Darryl Sexton, M.D.
City Health Officer

Nettie DeAugustine, Manager
Preventive Health Bureau

John Aguirre, Supervisor
Epidemiology

Michael Davis
HIV Epidemiology Program Supervisor

Tamara Purnell
HIV Epidemiology Program Assistant

Michael Ganz
Public Health Investigator

Hanan Obeidi, M.P.H.,C.H.E.S.
Epidemiology Analyst

Christina Kau, Data Manager
Preventive Health Bureau

Single copies of this report are available free from the Long Beach Department of Health and Human Services, Preventive Health Bureau, HIV Epidemiology Program, 2525 Grand Avenue, Long Beach, CA 90815; telephone (562) 570-4311. This report is also available on the City of Long Beach Web Site at www.ci.long-beach.ca.us/health.

HIV/AIDS Monitoring Report

City of Long Beach
Department of Health and Human Services
HIV Epidemiology Program
2525 Grand Avenue
Long Beach, CA 90815

HE1207-03

Attention Health Care Providers

The California Code of Regulations, Title 17, Section 2500, requires the report of communicable diseases and conditions. To report a case of a communicable disease, contact the City of Long Beach Department of Health and Human Services Epidemiology Program at 562-570-4302 or by fax at 562-570-4374.

Reportable Communicable Diseases

HIV/AIDS)✉
Amebiasis)✉FAX
Anisakiasis)✉FAX
Anthrax ☎
Babesiosis)✉FAX
Botulism ☎
Brucellosis☎
Campylobacteriosis)✉FAX
Chancroid
Chlamydial Infections
Cholera ☎
Ciguatera Fish Poisoning ☎
Coccidioidomycosis
Colorado Tick Fever)✉FAX
Conjunctivitis, Acute Infectious of the Newborn)✉FAX
Cryptosporidiosis)✉FAX
Cysticercosis
Dengue ☎
Diarrhea of the Newborn ☎ (Outbreaks)
Diphtheria ☎
Domoic Acid Poisoning ☎
Echinococcosis
Ehrlichiosis
Encephalitis)✉FAX
Escherichia coli O157:H7 ☎
Foodborne Disease)✉FAX †
Giardiasis
Gonococcal Infections
Haemophilus Influenzae)✉FAX
Hantavirus Infections ☎
Hemolytic Uremic Syndrome ☎
Hepatitis, Viral)✉FAX
Kawasaki Syndrome
Legionellosis
Leprosy
Leptospirosis
Listeriosis)✉FAX
Lyme Disease
Lymphocytic Choriomeningitis)✉FAX
Malaria)✉FAX
Measles)✉FAX
Meningitis)✉FAX
Meningococcal Infections ☎
Mumps
Non-Gonococcal Urethritis
Paralytic Shellfish Poisoning ☎
Pelvic Inflammatory Disease
Pertussis (Whooping Cough))✉FAX
Plague, Human or Animal ☎
Poliomyelitis, Paralytic)✉FAX
Psittacosis)✉FAX
Q Fever)✉FAX
Rabies, Human or Animal ☎
Relapsing Fever)✉FAX
Reye Syndrome
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
Salmonellosis)✉FAX
Scombroid Fish Poisoning ☎
Shigellosis)✉FAX
Smallpox (variola) ☎
Streptococcal Infections)✉FAX (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
Swimmer's Itch)✉FAX
Syphilis)✉FAX
Tetanus
Toxic Shock Syndrome
Toxoplasmosis
Trichinosis)✉FAX
Tuberculosis)✉FAX
Tularemia ☎
Typhoid Fever)✉FAX (Cases and Carriers)
Typhus Fever
Varicella (deaths only) ☎
Vibrio Infections)✉FAX
Viral Hemorrhagic Fevers ☎
Water-associated Disease)✉FAX
Yellow Fever ☎
Yersiniosis)✉FAX
OCCURRENCE of ANY UNUSUAL DISEASE ☎
OUTBREAKS of ANY DISEASE ☎

Reportable Noncommunicable Diseases/Conditions

Alzheimer's Disease
Cancer
Disorders Characterized by Lapses of Consciousness

)✉FAX = Report by FAX, telephone, or mail within one (1) working day of identification.

† = Report immediately by telephone when two (2) or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness.

☎ = Report immediately by telephone.
All other diseases/conditions should be reported by FAX, telephone, or mail within seven (7) calendar days of identification.